



# NPAIHB POLICY BRIEF

## Brief Analysis of President's FY 2010 IHS Budget

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

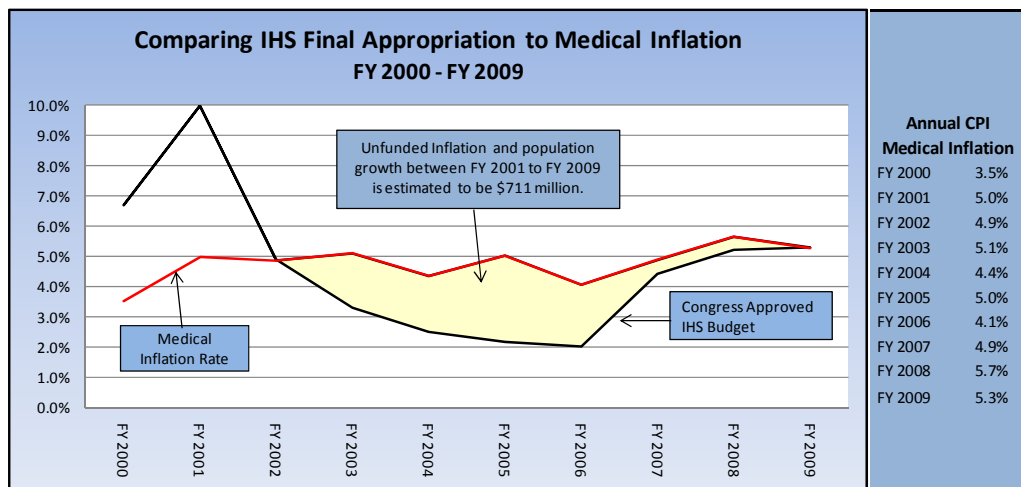
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(REVISED)

### President Obama proposes \$418 million increase for Indian Health Service and Tribal health programs

**“Expands Access to health Care for American Indians and Alaska Natives** - The Budget includes over \$4 billion for the Indian Health Service (IHS) to support and expand the provision of health care services and public health programs for AI/ANs. Investments in the Indian health focus on improving the health outcomes of AI/ANs and promoting healthy Indian communities. The President’s Budget builds upon resources provided in the recovery Act for IHS.”

*President Barack Obama’s  
HHS Budget Blueprint*

On February 26, 2009, President Obama released a blueprint of his FY 2010 spending plan, which reportedly provides more than \$4 billion for the Indian Health Service (IHS) to expand access to health care for American Indian and Alaska Natives (AI/AN). The full details of the President’s proposed budget are still not available, making it difficult to conduct any type of analysis on his proposal for the IHS. Using the FY 2009 omnibus as a baseline it’s projected that President’s proposed increase for the IHS should be at least \$418 million in FY 2010. While this is a very good budget increase for the IHS—without the full budget details—it is not possible to determine if this is a good budget for Indian health programs. The key to the President’s proposed budget is whether the request includes third party reimbursements or if funding provided in the American Recovery and Reinvestment Act (ARRA or stimulus) are used to offset appropriations to the IHS in FY 2010. If the President’s proposal includes Medicare or Medicaid collections, the budget may not be as good as everyone may think. If it does not include collections, then President Obama’s request is perhaps the best request for the IHS in the last twenty years.



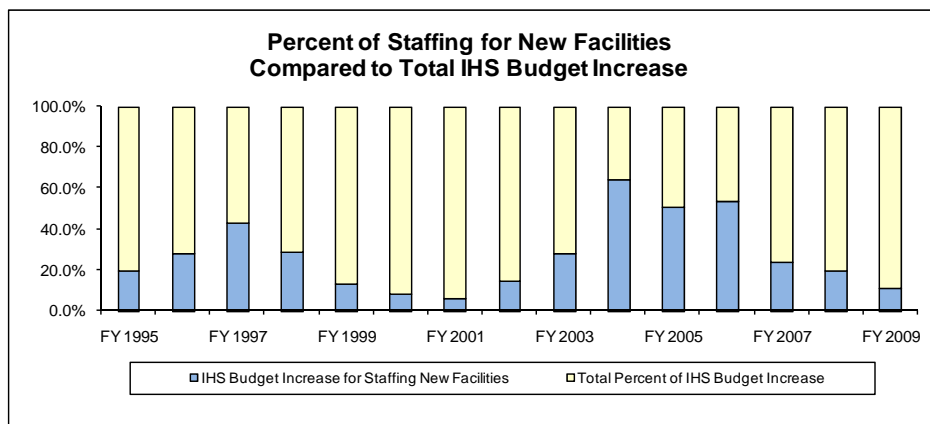
The FY 2009 omnibus provides \$3.58 billion for IHS and Tribal health programs however will fall short of the estimated \$513 million needed to maintain current services. Funding to maintain current services over the last eight years has not kept pace with medical services inflation, pay act increases, population growth, or contract support cost funds needed to operate health programs. As a result, Tribes have either had to cut health services or use tribal funds to absorb these

mandatory costs. It is estimated that the IHS has lost over \$711 million in unfunded inflation and population growth over the last eight years.

Recommendation: The President and Congress should recognize the fact that the IHS budget has lost significant purchasing power over the last eight years and work to restore this lost funding.

**Facilities and Economic Stimulus Funding**

A concern for Northwest Tribes is that the economic stimulus bill passed by Congress included \$227 million for only two facility construction projects located in two states. Tribes are concerned that when Congress passed ARRA it intended to stimulate economies across the United States and Indian Country. Northwest Tribal leaders are dismayed by the fact that over 50 percent of the economic stimulus funds provided for facilities construction only went to fund two projects. Because funding for these construction projects came outside of the IHS appropriation, NPAIHB recommends that Congress provide the IHS with a special appropriation to phase in staffing at these new facilities. Otherwise, Tribes nationally will be penalized twice by the impact of the economic stimulus fund provided for these two facilities construction projects. First, Tribes nationally did not get a fair opportunity to participate in the \$227 million provided for ARRA facilities construction projects. Secondly, when IHS phases-in staffing at the two new facilities it is likely to take at least 50-60% of the budget increase in the year the projects come on-line.



The staffing requirements for newly constructed health facilities have always been a concern for tribes nationally and IHS Areas that are dependent on Contract Health Service (CHS) funding to provide health care. The significance of facilities funding, both for construction and staffing new facilities, is that it removes funds necessary to maintain current services (pay costs, inflation, population growth, and contract support costs) from the IHS budget increase. The graph above illustrates the significance of staffing new facilities on the IHS budget increase. Staffing packages for new facilities are like pay act costs in two respects: (1) They come ‘off the top,’ (i.e. they are distributed before other increases), and; (2) They are recurring appropriations. Northwest Tribes frequently ask: Why did our health program receive a 1% increase in funding this year when Congress provided a 6% increase for the IHS budget? In FY 2003, the IHS received a 2.1% increase; however Portland Area Tribes realized less than a 1% increase in their health care budgets. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. While the impact of staffing in the last three years has been negligible, it’s expected that the requirements to phase-in staff for the two projects funded under ARRA will exceed 60 percent of the IHS budget increase. This increase comes at the expense of Tribes nationally and since Tribes did not get an opportunity to participate equally, they should not be penalized twice.

Recommendation: Congress should provide a special appropriation for the staffing requirements for the two new projects funded by economic stimulus funds.

**FY 2010 Mandatory Cost Increases**

A basic budget principle of Northwest Tribes has always focused on preserving the basic health care program funded by the IHS budget. Preserving the purchasing power of the IHS base program should be the first budget principle, not an afterthought. How can unmet needs ever be addressed if the existing program is not maintained? Current services estimates’ calculate mandatory costs increases necessary to maintain the current level of services. These “mandatories” are unavoidable and include medical and general inflation, federal and tribal pay act increases, population growth, and administrative costs (contract support costs). The 10 percent increase received in FY 2001 was the last budget that allowed tribes to reduce denials of CHS services.

NPAlHB estimates the current services need in FY 2010 to be \$470 million. This is the minimum amount necessary to fund inflation, pay cost increases, population growth, and fully fund contract support costs. President Obama and Congress must continue to build on their commitment to address AI/AN health disparities by providing an additional \$55 million more than the Administration has requested for the Indian Health Service.

<b>FY 2010 Current Service Requirements</b>	
<i>Mandatory Cost to Maintain Current Services</i>	<i>Increase needed</i>
CHS inflation estimated at 7 percent	\$ 44,443
Health Services Account (not including CHS inflation estimated at 8.3%)	\$ 158,358
Contract Support Costs (unfunded)	\$ 200,000
Population Growth (estimated at 2%)	\$ 67,010
<b>Total Mandatory Costs</b>	<b>\$ 428,042</b>

The recommendations presented here extrapolate medical related components of the Consumer Price Index (CPI) as they relate to IHS budget account activity. For example, inflation for the Hospital and Clinic Services is measured using the Hospital and Related Services component of the CPI; which only measures inpatient and outpatient hospital related care. Similarly, inflation for Dental Services is measured using the CPI component for Dental care services. Footnotes are included in the attached spreadsheet to indicate which CPI components have been used to measure inflation for budget sub-sub activity. A reference to locate that measure is included in the footnote. Extrapolating CPI medical component indices is a standard economic forecasting method that allows accurate and defensible estimates to be developed. Whereas, the Office of Management and Budget routinely applies non-medical related inflation rates to the IHS budget, which underestimate the true funding need for health care programs.

The Urban program line item is estimated using the CPI chained index for Medical Care Services and includes prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eye care, and services by other medical professionals. Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report amount. The facilities account uses the general CPI index to measure inflation. Finally, 2.1% rate of growth (same as the IHS rate) is used to estimate population growth.

Recommendation: Congress should provide an additional \$70 million over the President’s request to fund mandatory costs and maintain current services. The President and Congress must use real medical inflation projections when recommending funding for the IHS budget.

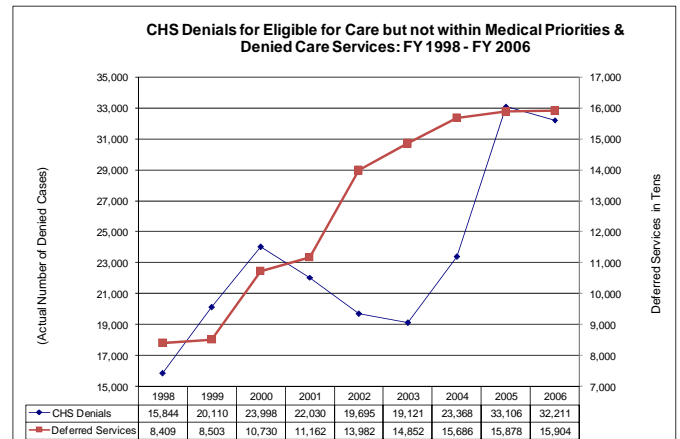
**Current Services Budget: Maintaining the existing Health Program and the President’s Proposed FY 2010 IHS Budget**

Current services estimates’ calculate mandatory costs increases necessary to maintain the current level of services. These mandatory costs are unavoidable and include medical and general inflation, pay costs, population growth and contract support costs. The Northwest Portland Area Indian Health Board estimates the FY 2010 current services need to be

approximately \$470 million. The President’s proposed increase for the Indian Health Service is projected to be \$415 million over the FY 2009 enacted level. Until the full budget details become available, the effect of the President’s proposal cannot be fully evaluated. If the projected increase of \$415 million does not include collections from the Medicare, Medicaid, and staff quarters, for the first time in ten years, comes close to being sufficient to maintain current services. An additional \$70 million is needed fully fund mandatory costs.

**CHS Denied and Deferred Services will rise due to inadequate funding**

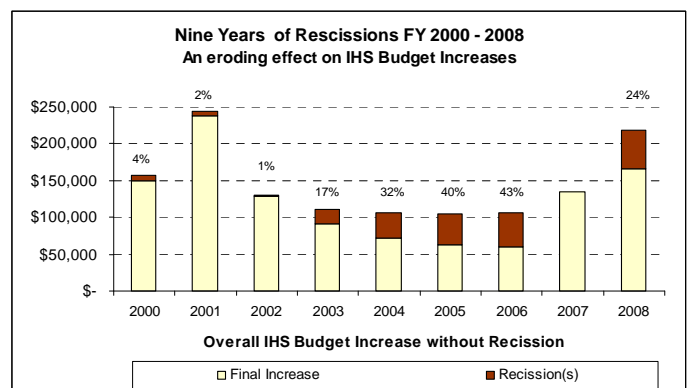
There is strong evidence that Contract Health Services (CHS) services will be cut due to inadequate funding. In FY 2001, the denied services in the CHS program fell for the first time in over five years. Denied services are those cases that are within the medical priorities for care, however there simply is not enough funding to cover the case. Thus, the patient must go without receiving care. Deferred services are those cases that are not within the medical priorities since there is not enough CHS funding and are left untreated. In FY 2001, a significant increase for the CHS program allowed some services to be restored. In 2001, the number of CHS denials declined for the first time since 1993. In FY 2008, the IHS deferred payment for 158,784 recommended cases totaling \$152 million. This is the highest amount that deferred payments in the CHS program have ever been. For the first time in five years these numbers dropped, however these reported amounts understate the actual unmet need since many tribes no longer report denied or deferred services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit IHS facilities because they know they will be denied services due to funding shortfalls.



Recommendation: Inadequate increases for the CHS program will ultimately mean increases in CHS denials once again in FY 2010 unless Congress restores and provides the IHS with an increase adequate to cover the costs of inflation and the growing Indian population.

**Rescissions continue to effect on the IHS Budget**

Rescissions have had a growing effect on Indian health programs over the last six years. The reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. In FY 2007, the IHS did not have a rescission because Congress passed a year long continuing resolution. Beginning six years ago, rescissions were a mere one percent of the approved IHS budget increase. Three years ago, the rescissions cut into almost half of the approved IHS budget increase. Why aren’t IHS health programs exempt from across-the-board reductions like the Veterans



Administration (VA) programs? IHS health programs are subject to the same rates of medical inflation that VA programs are and are deserving of the same consideration. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year’s rescissions and exempt them from future cuts.

## ***FY 2010 Budget Recommendations***

The Indian health system has made great strides to improve the health status of American Indian people. The President and Congress must continue to work to restore the funding that has been lost under the previous Administration or the gains in health status will be reversed and AI/AN health disparities will continue to grow. The current economic conditions are also affecting the Indian health system, which has seen a rise in the demand for health service and more individuals without third party coverage like Medicaid or private insurance. This means the IHS and Tribes cannot bill for third party collections that were once used to replenish IHS resources and expand services to other Tribal members. IHS and Tribes must now do even more with less. NPAIHB makes the following recommendations:

1. Congress must provide at least \$70 million more than the President's request to fund mandatory costs associated with maintaining current services.
2. The President and Congress should restore the \$711 million in lost purchasing power to the IHS appropriation by providing adequate increases over the next two fiscal years.
3. It is recommended that Congress provide the IHS with a special appropriation to phase-in staffing at the two new facilities funded by the American Investment and Recovery Act.
4. The IHS budget should be exempt from across the board cuts

The Congress must continue to preserve the basic health program that was funded in FY 2010 by providing an increase of at least \$470 million to the IHS budget. This recommendation is based on true inflationary rates developed using the CPI's medical components. Anything less than \$470 will leave IHS and Tribal programs with no alternative but to cut health services to Indian people. There simply is no other way for Tribes to absorb these mandatory costs.

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NPAIHB Policy Brief is a publication of the Northwest Portland Area Indian Health Board, 527 S.W. Hall, Suite 300, Portland, OR 97140. For more information visit [www.npaihb.org](http://www.npaihb.org) or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email [jroberts@npaihb.org](mailto:jroberts@npaihb.org).

## Indian Health Service Budget

Comparing H.R. 1105 to FY 2010 Current Services Estimates

(Dollars in Thousands)

	A	B	C	D	E (D x A)	F (2.1% x A)	G (E + G)
	<b>CURRENT SERVICES ESTIAMTES</b>						
Sub Sub Activity	House Approved H.R. 1105	President's FY 2010 Request	Change	CPI Medical Care	Increase needed for Inflation	Increase needed for Pop. Growth	NPAIHB ESTIMATE FOR INFLATION
<b>SERVICES:</b>							
Hospitals & Health Clinics	\$ 1,597,777	\$ 1,597,777	\$ -	6.7% <sup>a</sup>	\$ 107,051	\$ 33,553	\$ 140,604
Dental Services	141,936.00	\$ 141,936	\$ -	4.7% <sup>b</sup>	\$ 6,671	\$ 2,981	\$ 9,652
Mental Health	67,748.00	\$ 67,748	\$ -	4.9% <sup>c</sup>	\$ 3,320	\$ 1,423	\$ 4,742
Alcohol & Substance Abuse	183,769.00	\$ 183,769	\$ -	4.9% <sup>c</sup>	\$ 9,005	\$ 3,859	\$ 12,864
Contract Health Services	634,477.00	\$ 634,477	\$ -	7.0% <sup>d</sup>	\$ 44,413	\$ 13,324	\$ 57,737
<i>Total, Clinical Services</i>	\$ 2,625,707	\$ 2,625,707	\$ -		\$ 170,460	\$ 55,140	\$ 225,600
<b>PREVENTIVE HEALTH:</b>							
Public Health Nursing	\$ 59,885	\$ 59,885	\$ -	4.9% <sup>c</sup>	\$ 2,934	\$ 1,258	\$ 4,192
Health Education	15,723	\$ 15,723	\$ -	4.9% <sup>c</sup>	\$ 770	\$ 330	\$ 1,101
Comm. Health Reps	57,796	\$ 57,796	\$ -	3.8% <sup>c</sup>	\$ 2,196	\$ 1,214	\$ 3,410
Immunization AK	1,823	\$ 1,823	\$ -	3.8% <sup>c</sup>	\$ 69	\$ 38	\$ 108
<i>Total, Preventative Health</i>	\$ 135,227	\$ 135,227	\$ -		\$ 5,970	\$ 2,840	\$ 8,810
<b>OTHER SERVICES:</b>							
Urban Health	\$ 36,189	\$ 36,189	\$ -	7.0% <sup>d</sup>	\$ 2,533	\$ 760	\$ 3,293
Indian Health Professions	37,500	\$ 37,500	\$ -	3.2% <sup>f</sup>	\$ 1,200	\$ 788	\$ 1,988
Tribal Management	2,586	\$ 2,586	\$ -	3.2% <sup>f</sup>	\$ 83	\$ 54	\$ 137
Direct Operation	65,345	\$ 65,345	\$ -	3.2% <sup>f</sup>	\$ 2,091	\$ 1,372	\$ 3,463
Self Governance	6,004	\$ 6,004	\$ -	3.2% <sup>f</sup>	\$ 192	\$ 126	\$ 318
Contract Support Costs	282,398	\$ 282,398	\$ -	3.2% <sup>f</sup>	\$ 9,037	\$ 5,930	\$ 14,967
<i>Total, Other Services</i>	\$ 430,022	\$ 430,022	\$ -		\$ 15,136	\$ 9,030	\$ 24,166
<b>TOTAL, SERVICES</b>	\$ 3,190,956	\$ 3,190,956	\$ -		\$ 191,566	\$ 67,010	\$ 258,576
<b>FACILITIES:</b>							
Maintenance & Improvement	\$ 53,915	\$ 53,915	\$ -	3.2% <sup>e</sup>	\$ 1,725	\$ -	\$ 1,725
Sanitation Facilities Constructio	95,857	\$ 95,857	\$ -	3.2% <sup>e</sup>	\$ 3,067	\$ -	\$ 3,067
Hlth Care Facilities Constructio	40,000	\$ 40,000	\$ -	3.2%	\$ -	\$ -	\$ -
Facil. & Envir. Hlth Supp	178,329	\$ 178,329	\$ -	3.2% <sup>e</sup>	\$ 5,707	\$ -	\$ 5,707
Equipment	22,067	\$ 22,067	\$ -	3.2% <sup>e</sup>	\$ 706	\$ -	\$ 706
<i>Total, Facilities</i>	\$ 390,168	\$ 390,168	\$ -		\$ 11,205	\$ -	\$ 11,205
<b>TOTAL, IHS</b>	\$ 3,581,124	\$ 3,981,124	\$ 400,000		\$ 202,771	\$ 67,010	\$ 269,781

**Summary of Costs to maintain Current Services:**

Contract Support Costs Shortfall Amount:	\$ 200,000
Inflation & Population Growth:	\$ 269,781
Program Enhancements (see p. 18):	\$ - 0%
<b>Total Current Services Budget:</b>	<b>\$ 469,781 13%</b>

**Inflation Rates Calculated as follows:**

<sup>a</sup> Hospital & Clinics inflation calculated using CPI Series CUSR0000SEMD: Hospital & Related Services (inpatient and outpatient related costs).

<sup>b</sup> Dental inflation calculated using CPI Series CUSR0000SEMC02: Dental Services.

<sup>c</sup> Inflation calculated using CPI Series CUSR0000SAM Medical Care Inflation (medical care commodities, medical care services, and hospital & related services).

<sup>d</sup> CHS inflation calculated using CPI Series CUSR0000SS5703: Hospital Outpatient Services.

<sup>e</sup> Urban Indian Inflation calculated using CPI Series CUSR0000SAM2: Medical Care Services (Prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eyecare, and services by other medical professionals)

<sup>f</sup> Inflation calculated using CPI Series SUUR0000SA0: Chained Medical Care Index all goods and services.

<sup>1</sup> Source: FY 2007 IHS Contract Support Costs Shortfall Report - amount required to address past year's CSC funding shortfall and growth for new and expanded Self-Determination and Self-Governance agreements.